maternal intoxication and therefore the lack of maternal clinical hypervitaminosis has little relevance to the discussion of the teratogenic potential of vitamin A.¹ It is evident that the conclusion of Mrs. Wild and her colleagues that "it seems unlikely that women who conceive soon after discontinuing oral contraception run any teratogenic risk from increased vitamin A levels" may yet be more definite than is warranted by their data and should not be accepted as final. Further work is required.—I am, etc.,

ISABEL GAL

Teddington, Middlesex

- ¹ Briggs, M., Briggs, M., and Bennum, M., *Contraception*, 1972, **6**, 276.
- ² Gal, I., Parkinson, C. E., and Craft, I., *British Medical Journal*, 1971, **2**, 436.
- ³ Gal, I., and Parkinson, C. E., *Contraception*, 1973, **8**, 13.
- ⁴ Bubb, F. A., *British Medical Journal*, 1974, **1**, 391.
- ⁵ Bodansky, O., Lewis, J. M., and Lillienfeld, M. C. C., *Journal of Clinical Investigation*, 1943, **22**, 643.
- ⁶ Lund, C. J., and Kimble, M. S., *American Journal of Obstetrics and Gynecology*, 1943, **46**, 207, 486.
- ⁷ Gal, I., and Parkinson, C. E., *International Journal for Vitamin and Nutrition Research*, 1972, **4**, 565.
- ⁸ Gal, I., Joint meeting of the Blair-Bell and Clinico-Pathological Societies, February 1972.

Complication of Proximal Gastric Vagotomy

SIR,—About a year ago a death following proximal gastric vagotomy was reported in your columns.¹ It appeared that the lesser curve of the stomach had sloughed. I am writing to describe a very similar case.

The patient was a lean, 64-year-old man with a 10-year history of peptic ulceration who had developed pyloric stenosis. On 7 March 1974 proximal gastric vagotomy and Heinecke-Mikulicz pyloroplasty were performed. In the initial postoperative phase there was delay in gastric emptying and a nasogastric tube was not removed till 11 March. On 13 March he suddenly collapsed with generalized peritonitis. At operation 45 minutes later it was found that the whole of the lesser curve of the stomach had sloughed between the two lines of ligatures placed on the blood vessels entering it. A 0.5-cm strip of adjacent mucosa was purple and obviously had a very poor blood supply. The peritoneal cavity was cleaned out and the defect in the stomach wall was closed with interrupted black silk. A Maurice Lee tube was inserted and the abdomen was closed with drainage to the lesser curve of the stomach. Leakage of gastric contents from the abdominal drain occurred on 25 March but gradually ceased and eventually the patient recovered completely.

The sequence of uneventful proximal gastric vagotomy, dissolution of the lesser curve on the sixth day, and recurrence of leakage 12 days later is exactly the same as in the previously reported case. I wonder whether there may have been other similar cases which have not been reported. If this is so surgeons may have to alter their impression that proximal gastric vagotomy is an operation almost completely free from undesirable sequelae.—I am, etc.,

JOHN H. WYLLIE

University College Hospital Medical School, London W.C.1

- ¹ Newcombe, J. F., *British Medical Journal*, 1973, **1**, 610.

Drugs for Gastric Ulceration

SIR,—Your leading article on gastric ulceration (27 April, p. 186) asks "Where is the clinician to turn when faced with this variety of drugs?" May I suggest that he

has very little to do with any of them. But, instead of trying to influence the "gastric acid secretory potential," tries relying instead on the natural neutralization of the gastric acid that occurs with natural foods and which is so seriously interfered with (especially by refining the carbohydrates) in our modern civilization.

Epidemiological evidence from all over the world and from prisoner-of-war camps in the last war shows the very close correlation between such interference and the incidence of gastric and duodenal ulceration¹ and has recently been much strengthened.² The striking absence of peptic ulceration in those peoples who do not consume refined carbohydrates and the closely related reduced buffering effects of these foods on the gastric acid merit the closest attention.—I am, etc.,

T. L. CLEAVE

Fareham, Hants

- ¹ Cleave, T. L., *Peptic Ulcer*. Bristol, Wright, 1962.
- ² Cleave, T. L., *The Saccharine Disease*. Bristol, Wright, 1974.

Pregnancy Associated with Copper-containing I.U.D.

SIR,—Pregnancy may occur in women with an intrauterine contraceptive device in situ.^{1 2} Usually the device stays embedded in the placenta or membranes and the thread tends to disappear as pregnancy advances. In one series,³ for instance, 33 patients using the Birnberg bow became pregnant. In only two cases the bow was expelled and in 31 it remained in situ. Out of 16 patients who became pregnant while using a Lippes loop the loop remained in situ in 13. In another series⁴ the contraceptive device was retained in utero in all 29 pregnant patients. However, in a study of an intrauterine contraceptive device containing copper wire (Copper-7, Searle) we noticed in 13 patients who became pregnant a feature that is uncommon with other devices. Twelve of the 13

patients had not expelled the device. In three of the 12 the Copper-7 remained in situ, as occurs with most devices, but in nine the device had descended and the stem lay with the tip just palpable within the external os.

Removal of a tailed intrauterine device has been reported to increase the abortion rate.⁵ In our limited experience, however, it would seem that when a Copper-7 device lies low in the cervical canal the placental site is not disturbed when the device is withdrawn. It is interesting to examine the possible reasons for this difference. One likelihood is that the shape of the device is such that it is pushed down by the conceptus instead of becoming trapped by it. The other possibility is that pregnancy occurs mainly when the device lies in such a way that much of the stem, which carried the copper, lies in the cervical canal. Though the exact mode of action of copper-containing devices is not fully understood the contraceptive action is probably effected by release of copper ions into the surrounding tissue fluids.⁶ The pregnancy rate is thus within certain limits dependent upon the surface area of the wire within the uterine cavity.⁷ It is therefore essential to ensure that when the device is inserted it lies right up against the fundus uteri.

We thank G. D. Searle & Co. for their help in this study.

—We are, etc.,

V. SIVANESARATNAM

I. S. PUVAN

D. K. SEN

Department of Obstetrics and Gynaecology, University of Malaya, Kuala Lumpur, Malaysia

- ¹ Tietze, C., and Lewit, S., *Intrauterine Contraception*. Amsterdam, Excerpta Medica, 1965.
- ² Wood, C., *Intrauterine Devices*. London, Butterworths, 1971.
- ³ Bolognese, R. J., et al., *Fertility and Sterility*, 1968, **19**, 294.
- ⁴ Wajtraub, G., *Fertility and Sterility*, 1967, **18**, 570.
- ⁵ Lewit, S., *Contraception* (Los Altos), 1970, **2**, 47.
- ⁶ Oster, G. K., *Fertility and Sterility*, 1972, **23**, 18.
- ⁷ Zipper, J. A., et al., *American Journal of Obstetrics and Gynecology*, 1969, **105**, 1274.

Clinical Public Health Doctors

SIR,—I welcome your leading article (18 May, p. 348) in stressing the current uncertainty of the future of the clinical medical officers but join issue with the statements, "Worse still the isolation of the school health service is to be perpetuated, since it is to be put in the charge of the area specialist in community medicine (child health)" and later, "The appointment is not consistent with the concept of a district department of child health and furthermore is seen by many experienced child health principal medical officers as the imposition of another doctor above them, thus degrading their own position."

In the former large local authorities there was the medical officer of health and principal school medical officer in titular charge of the service, usually supported by a senior medical officer for school health responsible for the day-to-day administration. In the new service the area specialist in community medicine (child health) is responsible to the local education authority, not the area medical officer, so that one community physician is responsible for the school health service. I cannot see where there is the

imposition of another doctor—the situation is the reverse.

I cannot understand how you can justify your statement about the perpetuation of the isolation of the school health service from the document "Child Health Services (Including School Health Services)" (HRC (74)5). One of the main functions of the whole sphere of operation of the medical aspects of community child health. Nothing in HRC(74)5 precludes the future creation of district specialists to help to provide a comprehensive district child health service and I would agree that the main role of the area specialist should be co-ordination, epidemiology, and medical education.

However, I agree with the main theme of your article. There is a feeling among clinical medical officers that the majority of administrators at area and district levels have come from the hospital services and have little knowledge of community child health. No career structure has been agreed, and to await the Court Committee's findings, possibly late in 1975, shows a lack of realism regarding the work to be carried out now. Experienced staff are leaving the

service and as mentioned, there is little new recruitment. What we need urgently are established career structures together with compulsory in-service training at various levels to maintain the present services and expand them in a more specialized manner on a comprehensive basis. Let us hope that the situation can be saved.—I am, etc.,

C. SIMPSON SMITH

Ossett, Yorks

Working Hours of Junior Staff

SIR,—The consultants of this hospital have carefully considered ways of implementing the proposed off-duty hours for their juniors. The practical difficulties in achieving this are, however, very great for the following reasons:

(1) The acute services are divided between several hospitals some distance apart, in addition to the outlying psychiatric hospitals, and this greatly reduces opportunities for cross-cover between firms.

(2) Any reduction at all in the already limited junior staff cover available for intensive care areas (coronary, renal, and neuro-surgical intensive care, special care babies) would result in these units being unable to function in their proper capacity.

(3) Departments admitting mainly emergencies, such as neurosurgery, obstetrics, and paediatrics, demand the training and expertise of their own junior staff, who must be immediately available. Obtaining off-duty cover from other specialties would create unacceptable risks besides being unfair to the juniors concerned.

(4) Because demands for treatment almost everywhere exceed the facilities, the work load of all departments is heavy and turnover of patients necessarily rapid. Juniors, when on duty, are therefore fully occupied with their own work, and covering additional departments is rarely a practical proposition.

(5) Many specialties are relatively understaffed, particularly with registrars because of the longstanding "freeze," and there are few senior registrars to help out.

Opportunities for providing the extra off-duty cover from juniors is therefore severely limited in this hospital, and a similar situation is likely to exist in many other peripheral hospitals. We are in entire agreement with our colleagues at King's College Hospital (6 April, p. 51) that consultants must not be expected to do the work of their juniors in addition to their own, which for many consultants already means on-call duty in excess of 80 hours per week. It is in our opinion imperative that the existing teams of senior and junior medical staff responsible for patient care at this hospital are not disrupted. Further increase in time off, desirable though it is, will depend on increasing staff at all levels. We can therefore see no alternative to the additional provision of extra-duty payments on a large scale.—We are, etc.,

J. G. DUMOULIN
Chairman
M. J. GRAYSON
A. C. HUNT
M. T. INMAN
PETER MEERS

W. E. STRACHAN
MICHAEL W. REECE
M. KEITH STRELLING
KENNETH WEEKS
R. D. SWEET
J. A. C. STRACHAN

Members, Medical Executive Committee

Plymouth General Hospital,
Plymouth

Consultant Crisis

SIR,—The disillusion and pessimism over conditions of service expressed by the consultants of Rochdale (25 May, p. 447) are widely if not universally shared by their colleagues in other areas.

They are right that gentlemanly negotiations with a monopoly employer by a politically negligible and internally divided body of 11,000 persons (whose corporate image has moreover become distinctly uncharismatic) are doomed to failure. They are wrong to suppose that consultants have any real powers of sanction, however. Their suggested measures, "total withdrawal from medical executive committees, management teams, etc.," are not only futile in themselves but will delight rather than dismay those of our political and administrative masters who claim that consultants have had too much say already. Your correspondents go on, "the option for sterner measures should be kept open." One is reminded of the impotent vapourings of Shakespeare's King Lear (also in a situation of having over-estimated his strength): "I will do such things—what they are yet I know not; but they shall be the terrors of the earth."

Do the consultants of Rochdale mean that they will stop treating N.H.S. patients? That is the *only* sanction that would bite, but it would be an irredeemably disgraceful one which few doctors either could or would operate. Our employers know this. The public know it. I know it. I am sure the consultants of Rochdale know it. What, then, is their secret weapon?—I am, etc.,

P. J. E. WILSON

Department of Surgical Neurology,
Morrison Hospital,
Morrison, Swansea

Finance and the Health Service

SIR,—Your leading article on this subject (25 May, p. 398) seems to avoid one central part of the problem which tends to be avoided by those straining for better pay and conditions, usually for less work. The "national cake" is not increasing to provide improved standards; therefore at whose expense would the "bigger share" of the national cake be found? Unless it is found from an increase in the gross national product or from some other section of society the addition to the inflation that it will create will eliminate any real improvement.

We will now never move away from "the concept of a free comprehensive service" but a proper emphasis on the cost-economy of the N.H.S. and the avoidance of expensive frills could lead to considerable saving. Everywhere in the N.H.S. it should be emphasized that each costly innovation, administrative, nursing, or medical—and many spring to mind, has to be introduced at the expense of some other group or service. There is at present no other way.—I am, etc.,

J. C. SCOTT

Cuddesdon, Oxford

SIR,—With strike action again darkening the doors of the Health Service I think it is time, though I do not know how, that we as doctors brought some greater influence to bear to try and improve the lot of our

service as a whole. The whole service is being run on a fast-fraying shoe-string and patient care is deteriorating. The nurses obviously deserve more pay and should get it, but the whole service has got to get a larger cake altogether. Future generations may well lay a lot of the responsibility for a scandalous service at the door of doctors, who, when all is said and done, have the prime responsibility for patients.

With Britain's decline and dwindling economy, our Government will have to change its policies, possibly reducing expenditure on defence, and make a large increase in its Health Service expenditure. Unless this is forthcoming, I think it could well be the responsibility of doctors, hopefully combined with everyone else in the service, to call for voluntary contributions again to run the service properly. A National Health Service is one of the few nationalized industries which ought to work, but if it does not then it must be our responsibility to find an alternative.

Strike action is out of the question; it delays patient care and inevitably increases suffering and death, no matter how vehement people are that emergency services are covered.—I am, etc.,

S. R. BRENNAN

Royal Hospital, Sheffield

Practice Expenses

SIR,—Dr. T. W. May and his colleagues (1 June, p. 506) may be "appalled at the ludicrous estimate for increase in practice expenses for 1973/74," but the fact remains that these estimates are based on Inland Revenue returns of the amounts actually spent by general practitioners and accepted by local inspectors of taxes as allowable under Schedule D. Experience has shown that the estimates made in previous years have proved to be remarkably accurate when subsequently compared with the actual Inland Revenue returns for the years concerned.

When the Memorandum on Practice Expenses (Annual Report of the General Medical Services Committee 1974, appendix IV) was prepared the details of the new administration's Budget were not available, and the effect that they will have on practice expenses in 1974/75 could not, therefore, be incorporated in the estimate. Local medical committees have since been informed that these effects have been brought to the attention of the Review Body, which has confirmed that a consequential upward revision of the estimate will be made in the current review, the report of which should be available by the time this letter is published.

Meanwhile, when considering the figures to which your correspondents refer, it is important to remember, as readers of the Annual Report will have noted, that the practice expenses estimates do not include the considerable direct payments to general practitioners for rent and rates and ancillary staff (paragraphs 51 and 52 of the Statement of Fees and Allowances) and represent only those expenses which are to be reimbursed through gross fees and allowances.—I am, etc.,

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